MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address RS Medical P O Box 872650 Vancouver, WA 98687-2650	MDR Tracking No.: M4-03-A077-01
Respondent's Name and Address Texas Mutual Insurance Company P O Box 12029 Austin, Texas 78711-2029 Box #54	Insurance Carrier's No.: 99D0000335713

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
4/14/03	5/13/03	E1399-RR	$100.00	$100.00
5/14/03	6/13/03	E1399-RR	$100.00	$100.00

PART III: REQUESTOR'S POSITION SUMMARY

The Requestor's position statement states in part, "…Payment has been made on the old fee guidelines for E0745; which had a D code in the pre 1996 fee schedule, which is not a comparable device as it provides only muscle stimulation. …The RS4I provides 2 modalities…4 channel muscle stimulation plus interferential electrotherapy, providing equivalent therapy of 2 devices, therefore a higher fee allowance is reasonable and warranted. The RS4I provides relief and promotes muscle recovery to the injured worker. …Therefore, reimbursement for this unit under the fee schedule for E0745, which is a muscle stimulator only, is neither fair nor reasonable.

PART IV: RESPONDENT'S POSITION SUMMARY

The Respondent's position statement states in part, "…The fair and reasonable reimbursement is based on the following rationale. The amount was calculated by using the allowable amounts in the 1991 Medical Fee Guidelines for code D0550 (muscle stimulator). The listed amount for the code is $150.00 rental per month, the same amount reimbursed by the carrier. Accordingly nom further reimbursement is due…"

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

The Carrier denied additional reimbursement as F 01 – The charge for the procedure exceeds the amount indicated in the fee schedule. M YM – The reimbursement for the service rendered has been determined to be fair and reasonable based on billing and payment research and is in accordance with Labor Code 413.011(D)."

Texas Labor Code 413.011 (d) and Commission Rule 133.304 (i)(1-4) places certain requirements on the Carrier when reducing the services for which the Commission has not established a maximum allowable reimbursement. The Respondent is required to develop and consistently apply a methodology to determine fair and reasonable reimbursement and explain and document the method used for the calculation. The did not show their rate to be a fair and reasonable rate of reimbursement.

Per Rule 133.307 (g)(3)(D), the Requestor is also required to discuss, demonstrate and justify that the payment being sought is a fair and reasonable rate of reimbursement. The Requestor has provided redacted sample EOBs as evidence that the fees billed are for similar treatment of injured individuals and that reflect the fee charged to and paid by other carriers. On this basis, reimbursement is recommended in the amount of $200.00 ($250.00 billed - $150.00 Carrier Reimbursement = $100.00 x 2 dos).

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
				Total Left Column:			$0.00
				Total Amount Due:			$0.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of **$200.00.** Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Authorized Signature	Pat DeVries Typed Name	January 31, 2005 Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____